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CASE STUDY

The shared journey of induced lactation: A case study

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ABSTRACT

Background: Induced lactation or adoptive breastfeeding is a little-spoken-of event and can be life-changing for participants. While not common, it is nonetheless within our realm of practice as midwives and, therefore, important that we understand how our role can support whānau who make this choice.

Aim: The aim of this case study is to share a narrative of induced lactation and adoptive breastfeeding from the midwifery and whānau perspectives. The multilayers of midwifery care evident in this case study and breastfeeding success will be discussed, with the hope that this can also support midwives who are caring for LGBTQIA+ whānau who are inducing lactation.

Method: This is an anonymised, "instrumental" case study that offers a first-person practitioner narrative and reflection of a single case, representative of a phenomenon that most midwifery tauira (see glossary) and early-career midwives may not readily observe first-hand.

Discussion: Three important outcomes are noted. First, the intrapersonal and psychosocial factors that are part of the narrative were incorporated in a care plan providing holistic assessment and clinical decisions, acknowledging the gift of breastfeeding that carried a much larger significance than purely a nutritional choice. Second, collegial relationships support an inclusive experience for all involved. Third, re-telling, reflecting on and analysing the various elements in Anna's story offer an educational example for in-depth learning and understanding.

Conclusion: The professional responsibility of the midwife was a part of the process, and integral to Anna's positive experience of induced lactation.

Keywords: induced lactation, adoption, breastfeeding, midwifery care, education

INTRODUCTION

This case study is a love story, a story of commitment, courage and perseverance. It is a story of becoming a parent and of partnerships. It is a story of great challenges and immeasurable joy. Pseudonyms Anna and Mark (adoptive mother and father), Alex (birth parent), and Lou (baby) are used throughout. The adoptive parents have explicitly given their consent for the sharing of this story. They feel strongly that the story should be shared, in the hope that it may support another whānau (see glossary). It must be acknowledged that I am both the author and Anna's midwife. This can be seen as a limitation and as a positive lens of shared experience.

Anna and Mark, a Pākehā couple in their late 30s, had been trying to have baby for a few years; however, six cycles of IVF support had not delivered the happy news they were hoping for. They made the decision to be available to adopt a baby and to apply to become permanent caregivers. Anna and Mark were consequently contacted by an agency putting them in contact with Alex, the birth parent. Anna wanted to engage in midwifery support and care, so I arranged to meet her to discuss the plan for postnatal care and my role in her care.

It was important to sit and hear Anna's story to support her in a way that was meaningful and that would meet her individual needs. We spent time sharing the heartache of infertility and the path that led her here. Our partnership was beginning, and I was privileged to share this journey (New Zealand College of Midwives [NZCOM], 2015). Typically, the philosophy of midwifery care does not separate parent and baby; they are viewed as one and the care provided meets the needs of both (Guilliland & Pairman, 2010). In this situation, however, the initial partnership was solely focused on the needs of Anna. The beginning of our midwifery journey was unique in this sense.

Anna was keen to breastfeed her baby, Lou, and asked if this was possible. Anna came from a family where breastfeeding was

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supported and encouraged and she, herself, had been breastfed. Anna understood the health benefits and the important role breastfeeding had in attachment and bonding. Cazorla-Ortiz et al. (2020) support this and identify the main reasons for inducing lactation are to develop closeness and satisfy nutritional needs. Mark was very supportive of Anna breastfeeding their baby and was completely on board with doing whatever was needed. Previous studies have shown that the vicarious experience of breastfeeding can impact on the intention a mother has to breastfeed; prior exposure and experience of breastfeeding for family members, perceived support from social networks and the role of the partner in providing emotional support have all been documented as being invaluable for success (Bartle & Harvey, 2017; Lok et al., 2017; Rempel et al., 2017). Further, the intention to breastfeed significantly impacts on the initiation and duration of the breastfeeding relationship (Lok et al., 2017).

Anna's commitment to breastfeeding meant she was interested in inducing lactation and providing supplemental nutrition at the breast. As she was not pregnant, or giving birth, her body would not be hormonally engaged in lactation. Anna knew that inducing lactation would come with challenges and a need for commitment. Anna was completely willing to explore this and make it work for her. Choosing to breastfeed an adopted child is "the act of putting into practice the relation of love between two human beings" (da Rocha Lage et al., 2014, p. 250).

METHOD

An anonymised, "instrumental" case study method was used, offering a first-person practitioner narrative and reflection of a single case. The commentary uses gender-inclusive language to represent diversity of whānau receiving midwifery care. For reasons of fidelity, terms used in referenced literature will be used in this work. The adoptive parents are cis-gendered and, therefore, when speaking explicitly of their experience, the language used will be breasts, breastfeeding, woman, mother and pronouns she/her. When discussing physiology and protocol the term breasts will be used – this is in acknowledgement of the existence of breast tissue for all people. This paper refers to induced lactation for cis-gendered women and trans and non-binary people who were assigned female at birth. Induced lactation for trans women was beyond the scope of the paper. All care has been taken in protecting the anonymity of those to whom this story belongs.

Case studies as an educational method

To walk alongside a parent through their breastfeeding/chestfeeding journey is an honour. Continuity of care and the partnership we build create an ideal space to promote, educate and support (Guilliland & Pairman, 2010). In my role as a midwifery educator, I share with tauira that, as midwives, we have a unique role that enables us to provide support that is tailored to the birthing person within their whānau context, and that meets their individual needs. It is precisely because each journey is a unique one, that case studies as an educational tool are so valuable. They allow us to consider circumstances and choices that are less common, and therefore may not be encountered in clinical placements or early practice.

Higher education providers note the use of case studies to show the application of a theory or concept to real situations, especially where issues and outcomes are not pre-determined and/or there is no single correct answer (Vanderbilt University, 2022). Case studies can be effectively employed in multiple disciplines, including humanities, social sciences, medicine and health studies.

Case studies can be used as learning stories that explain, describe or explore events, or phenomena, in the everyday contexts in which they occur (Yin, 2009). Crowe et al. (2011) analyse the types of case studies used in health sciences and describe three main approaches: intrinsic, instrumental, and collective. An *intrinsic* case study is typically undertaken to learn about a unique phenomenon, whereas an *instrumental* case study (such as the subject of this article) shares a particular case to prompt a broader appreciation of an issue or phenomenon. The *collective* case study involves studying multiple cases – displaying similarities and differences. Case studies in general, but especially instrumental case studies, allow discussion of an event to be considered from multiple perspectives. Analysis and discussion can test theoretical and historical explanations and, in certain circumstances, allow students to consider theoretical generalisations beyond the case studied (Crowe et al., 2011).

In the present case study, the central issue was Anna's desire to breastfeed in an adoptive context requiring induced lactation, and the holistic considerations that accompanied this aspiration. There is strength in case study as a tool for the dissemination of practice experiences as in this situation. However, there are limitations as one experience, whilst illustrative, can not necessarily be generalised to other experiences and does not consider the many differing experiences had within adoption. Cazorla-Ortiz et al. (2020) agree that, whilst case studies are useful ways of sharing evidence and knowledge, they "do not produce enough evidence to generalize results or build an evidence base" (p. 746). It would be interesting for any future case studies reporting on aspects of induced lactation to consider the efficacy of differing ways of inducing lactation and the factors that are related to success. In doing so, we can build strong transferable evidence that will uphold midwifery and lactation support (Cazorla-Ortiz et al., 2020).

THE CASE

The breastfeeding decision

The challenge of inducing lactation and producing enough milk for a baby is very real when it has not been preceded by pregnancy. For Anna, it was clear that breastfeeding was not solely about nutrition. While the nutritional side was indisputably vital, any milk she made was a precious contribution. The spiritual and emotional aspects, and the sense of connection associated with breastfeeding, were extremely significant to her.

Decisions made about breastfeeding/chestfeeding are as complex and unique as the person facing the decisions. Midwives understand that these decisions are impacted by many factors and, as such, they must remain open to the many diverse factors that may present themselves during the care provided (Wilson et al., 2015). For Anna, the choice to breastfeed was high on her priority list and drew on her strong social and familial community which would be of tremendous support to her. We spoke often of this, and Anna communicated her desires and support systems to me. We spoke of the social context of induced lactation and the option of using donor milk. Anna acknowledged that there are still some taboos around donor milk sharing and feeding solely at the breast using another person's milk. For this reason, and to avoid emotional disruption for everyone, Anna chose to keep her circle small, and the news of the adoption was only shared with a few. Anna also recognised the separation and loss that her baby would experience after leaving the birth parent and wanted to alleviate as much of that as possible, through bonding and attachment. Anna having Lou from birth was extremely important to both Anna and the birth parent, Alex. Being party to and, at times, instigating these discussions, required a high level of trust (NZCOM, 2015).

Feeding challenges for parent and baby

The process of human milk production has three stages. Lactogenesis I and lactogenesis II are the hormonal and endocrine pathways arising from pregnancy and birth, and which are important for milk production (Bartle & Mandeno, 2019). When there has been no pregnancy, lactogenesis III can still be stimulated through induced lactation. Lactogenesis III occurs around day 10 postpartum when there is a switch from endocrine to autocrine regulation. The autocrine system is *local* – occurring within the breast, *chemical* – feedback inhibiter of lactation (discussed below) and *inhibitory* – the negative feedback loop. The amount of milk produced corresponds directly with the amount of milk removed from the breast (Bartle & Mandeno, 2019).

In relation to milk production, there are two factors controlling the synthesis: Feedback Inhibitor of Lactation (FIL) and prolactin. FIL is a small whey protein that appears to control milk production by slowing milk synthesis when breasts are full (more FIL present) and speeding synthesis up when breasts are empty (less FIL present).

The presence of prolactin is vital for milk synthesis to occur. Prolactin receptor sites are located on the wall of the lactocytes (alveoli milk-producing cells), allowing prolactin in the bloodstream to move into the lactocytes, supporting stimulation of breastmilk synthesis. When the alveolus is full of milk, these receptors change shape, inhibiting prolactin from entering the sites and decreasing the rate of milk synthesis. As breasts empty during feeding or expressing, the receptors return to their normal shape, allowing prolactin to enter again, increasing the rate of milk synthesis. Frequent milk removal at the initiation of breastfeeding increases the number of receptor sites. The more sites there are, the more prolactin can enter the lactocytes, increasing the milk production capability (Bartle & Mandeno, 2019; Bonyata, 2018).

The challenges for a baby are multiple and include the transition from birth parent to adoptive parent, ensuring sufficient milk transfer and therefore receiving adequate nutrition at the breast/chest. To appreciate the uniqueness of the situation for the adopted baby is to understand that they experience a sense of loss and separation. Carlis (2015) notes that the loss of the biological mother connection is real. This connection may have been loving and positive, or it could have been fraught with stress and anxiety, but it was attachment and connection, nonetheless. As Ryan (2012) states, "ALL adoptions involve a loss for the child. Even a newborn infant who is placed right into the loving arms of his adoptive parents is being separated from the only mother he knows" (para 5). Creating a space that respected this while becoming a nurturing and loving haven was so important to Anna.

Anna accepted that she may not make sufficient milk to meet all her baby's needs. The challenge was to support effective breastfeeding and milk transfer whilst providing appropriate amounts of donor milk via lactaid (a supplemental nursing system). To support the production of as much milk as possible, the baby's latch and suckle needed to be effective (Bonyata, 2018). Stimulation is vital for milk production; this is true regardless of the use of pharmacological methods or not (Cazorla-Ortiz et al., 2020).

A potential barrier to this was that the current adoption processes require a baby to be in foster care from birth until 12 days. This is to give the birth parent time to be certain of their choice and provide ease of visitation (Adoption Act, 1955). Steps 6 and 9 of the 10 steps to successful breastfeeding state that to support and promote breastfeeding we need to avoid anything other than human milk, unless medically indicated, and to educate parents on the use and risks of feeding bottles (World Health Organization [WHO], 2018). Having the breast available, and supplementing food by means other than a bottle, promote the success of breastfeeding long-term (Cazorla-Ortiz et al., 2020). Navigating the adoption process regarding the 12 days of foster care was another challenge in Anna's journey, and an example of the need for a strong relationship between Anna and myself.

Midwifery care plan – holistic assessment and information sharing

Accurate and up-to-date information must be shared to enable informed decision-making (NZCOM, 2016) and to uphold the rights of the parent to breastfeed/chestfeed and the child to be breastfed/chestfed.

Anna and I discussed the Newman-Goldfarb accelerated protocol for inducing lactation (Goldfarb & Newman, 2019). This involves the use of hormonal support, in the form of a combined oral contraceptive pill (oestrogen and progesterone) combined with domperidone, 20mg four times a day, to mimic pregnancy changes. Domperidone impacts on serum prolactin levels and the following side effects can occur: a dry mouth, cramps, fast heartbeat, diarrhoea, anxiety or sleeplessness and headache (McBride et al., 2023). When breast changes are noticed, the oral contraception is discontinued, and pumping begins alongside domperidone (Goldfarb & Newman, 2019). The Newman-Goldfarb protocol was developed to support a cis-gendered woman to breastfeed her baby born via surrogacy. Inducing lactation is a commitment that takes dedication and time; this needs to be acknowledged in the discussions and care planning.

As Anna was not currently pregnant, I was unable to prescribe for her (Midwifery Council, 2010). Domperidone is currently unapproved for use in maternity care, therefore Anna would need to go to her general practitioner for any prescriptions required (NZCOM, 2010). The protocol for inducing lactation can start as soon as the breastfeeding/chestfeeding parent is aware that a baby is coming. This can be six months before due date and continue while the parent's milk supply is building. The regime for pumping is prescriptive and outlined clearly in several sources and begins approximately 6 weeks before baby is due, after stopping the contraceptive pill and continuing with domperidone and/or herbal galactagogues (Canadian Breastfeeding Foundation, n.d.-a; Cazorla-Ortiz et al., 2020; Goldfarb & Newman, 2019; Wilson et al., 2015). In summary, the steps are (Canadian Breastfeeding Foundation, n.d.-a; Goldfarb & Newman, 2019):

1. Simulate the first 24 hours of feeding – pump 2-hourly during the day, and 3-hourly overnight. Pattern: pump both breasts for 5-7 minutes, then massage, tickle and jiggle (to assist milk ejection reflex), then pump each breast for a further 5-7 minutes.
2. Post first 24 hours – pump 3-hourly and once overnight. Pattern: pump breasts for 5-7 minutes, then massage, tickle and jiggle, then pump each breast for 3-5 minutes.

The use of herbal galactagogues, such as fenugreek and blessed thistle, and homeopathy to support induced lactation was also discussed. Herbal galactagogues may be used in conjunction with stimulation in the form of pumping regimes to induce lactation (Cazorla-Ortiz et al., 2020; Wilson et al., 2015). I encouraged Anna to consult with a herbalist and homeopath for support with these, as her requirements would be specific to the situation and beyond my scope of practice and expertise (NZCOM, 2018).

As part of a holistic assessment, it was vital for me as her midwife to unpack the emotions and desires attached to Anna's choice to induce lactation and breastfeed Lou. I encouraged Anna to think about what breastfeeding success looked like for her. Individual and whānau priorities needed to be addressed so appropriate support and up-to-date information could be given, including nutritive and non-nutritive benefits (Wilson et al., 2015).

In preparation for breastfeeding and to ease Lou's transition, negotiation occurred by Anna's lawyers with Oranga Tamariki | Ministry for Children for Lou to go straight to Anna from birth. In support of this, Anna wrote a letter that highlighted the value of the attachment and bonding that occurs from birth, which promotes emotional security and independence in later years (Buckley, 2009; Phillips, 2013). Permission was granted for Lou to remain a ward of the state for the 12 days required, in Anna's and Mark's care. The birth parent, Alex, was able to visit if she wished. This meant that Lou would receive all nutrition at Anna's breast from birth, with no disruption to bonding and attachment.

Anna was very aware of the important health benefits of human milk and, while breastfeeding, planned to avoid using formula, instead preferring donor milk to supplement to maintain the best health options for Lou. This position is directly aligned with good practice, as outlined by the New Zealand College of Midwives (NZCOM, 2019): "In situations where mothers' own milk is not available, human milk from a donor mother is considered to be an appropriate substitute when both the donor and recipient mother/guardian give informed consent" (recommendation 3). La Leche League GB (n.d.) also advocates the use of human milk for human babies, noting that the benefits include, but are not limited to, giving the baby optimal nutrition that is easily digestible and providing immunological protection. The organisation also notes the proviso that possible risks must be considered, including, but not limited to, the transmission of certain infectious agents, medicines or other drugs and environmental contaminants.

I shared with Anna the Facebook page *Human Milk 4 Human Babies, Piripoho Aotearoa* as a resource for finding donor milk. Potential risks were minimised as women donors were offering their blood screening results and disclosing medication and dietary intake. This type of disclosure is also supported through practice recommendations on consent, screening and documentation surrounding the use of donor milk (NZCOM, 2019).

Anna wanted to keep the adoption quiet until Lou was born, so asked me if I would be able to post her request for donor milk on the milk-sharing Facebook page, on her behalf. The request was met with an outpouring of loving thoughts, well wishes and offers of milk. All potential donors were put in direct contact with Anna. She found herself immersed in a community of loving women and, as she termed it, "milky goodness". By the time Anna's baby was born, there was enough milk in her deep freeze to last the first three months of breastfeeding. As a midwife, I was also able to source 40 millilitres of donor colostrum for Lou. This was ideal as colostrum is important in newborn gut health and immune system through the "establishment of bifidus flora in the digestive tract" (Rankin, 2017, p. 572). The willingness of other parents to support Anna, Mark and Lou was humbling and truly beautiful.

Alex invited Anna to attend Lou's birth, while Mark and I waited for Anna and the newly-born Lou in the room next door. Previous conversations with Alex's midwife, who was in complete support of Alex's and Anna's plans, enabled an ease of care for the people in the two rooms. Through the collegiality of all involved, we were able to create a space of loving support for Anna, Alex, Mark and baby Lou. This collaboration promoted the best outcomes and maintained the dignity of everyone involved (NZCOM, 2015). Alex's midwife held the space for her in a way that was authentic, defined by Alex and ensured the best outcome for her as she farewelled her baby. Both Anna and Mark respected that the process be inclusive of everyone's needs. There were palpable grief, awe, relief and overwhelming joy felt by all that night.

Midwifery care plan - clinical plan and outcomes

Anna decided to not follow the Newman-Goldfarb protocol as written, taking a more relaxed approach. We discussed a plan that Anna felt was achievable and supported her beliefs about health. Anna planned to hire a hospital-grade double pump and pump as able. During the working week, she would aim for 4-hourly and once overnight, and over the weekend planned to pump 3-hourly. Anna chose not to take the contraceptive pill or domperidone, although was open to using domperidone later if needed. Anna supported her process with herbal formulas she bought from a medical herbalist. This plan was to continue until Lou's birth and then be reviewed.

Anna noticed breast changes within a few weeks of pumping and taking herbs, in particular an increase in overall breast fullness and in her areolae. After a few days of pumping a clear oily substance was expressed, and then nothing for a few weeks. Anna was eventually able to pump small amounts of milk, drops to start with. By the time Lou was born, this had increased to a few millilitres.

Through pumping only, some milk production can occur. The Australian Breastfeeding Association (2018) states that pumping 6-8 times a day can, for some people, produce milk. However, it is also worth noting that this may be of lesser quantity than for those who use the full protocol (Goldfarb & Newman, 2019), therefore supplementation is often needed.

Interestingly, the Canadian Breastfeeding Foundation (n.d.-b), citing a 1991 textbook, states that studies indicate the milk from women (also trans and non-binary people assigned female at birth) who induce lactation is comparable in composition to breastmilk from a biological mother when tested at 10 days postpartum.

Anna understood how the physiological processes of birth impact the long term success of the breastfeeding journey and therefore developed a plan, together with the birth mother, to support Lou's physical and emotional transition as an adopted baby. The plan, if all went as hoped, was as follows. As soon as able post-birth, Lou was to be put skin-to-skin with Anna and given the time to breast crawl. We created time and space for Lou to latch, suckle at the breast and be given colostrum via a plastic cannula from a wide gauge IV luer connected to a syringe. This aligns with steps 4, 6 and 9 of the widely used guideline *Ten steps to successful breastfeeding* (Bartle & Mandeno, 2019; WHO, 2018). This was significant for Anna as she claimed her place as Lou's mother.

Anna had planned for early discharge from hospital; however, as Lou's weight was over the 95th centile, the recommendation was to stay in the hospital to monitor Lou's blood sugars. Fortunately, the hospital was not busy and there were two rooms free – one for Alex and one for Anna and Lou. There was some "creativity" that went on during that stay on the part of the midwifery staff to assist with these arrangements. All were supportive and excited by Anna's story and wish to breastfeed, resulting in a great willingness to support all three: Alex, Anna and Lou. This reflects the profession's guiding philosophy of midwifery care as flexible, creative and punctiliously ethical regarding responsibilities to the whānau and baby (NZCOM, 2015).

The ongoing plan once home was for baby-led feeding and unlimited skin-to-skin contact.

Anna was going to use donor milk at the breast with every feed, in the amount Lou asked for, watching for milk transfer. Monitoring output as a guide for input was discussed and Anna kept a detailed record of feeds, including the amount of expressed breast milk (EBM) taken, at what point during the feed EBM was introduced, and all output. Anna continued pumping after baby feeds and was happy to review the need for this regularly.

Postnatal visits during the first two weeks felt like walking into a womb. The space created to support Lou's transition and establishment of breastfeeding was incredible. The curtains were often pulled, and the home was dimly lit and quiet. Anna was always skin-to-skin with baby, providing unlimited access to the breast and her heartbeat. It was a privilege to observe such gentle, respectful and loving parenting. Lou fed beautifully and regularly, taking what was needed from the breast alongside donor milk via lactaid. Anna pumped after feeds for the first week as required to ensure a good supply until Lou was spending a longer time at the breast. Anna controlled the flow of the lactaid to ensure the feed lasted at least 15 minutes. Steady and excellent weight gains were seen throughout the six-week period that I provided midwifery care.

Midwifery reflection

The role of the midwife is important when it comes to promoting and protecting breastfeeding/chestfeeding. The Human Rights Commission (2005) states that "children have the right to be breastfed if their mothers choose to breastfeed. Human rights law requires respect, protection, and facilitation by outsiders of the nurturing relationship between mother and child" (p. 7).

The opportunity to create the space for empowerment which leads to self-determination is a privilege and one that this experience shares with similar published accounts. "Participation in shared decision-making ensured women's agency" (Ryan et al., 2017, p. 320). Maintaining or, indeed, restoring agency requires support from health professionals that is informed and comes from a place of partnership. For Anna, it was important to approach her breastfeeding in her own way, space and time, and our journey together supported this.

The gifts I have received from sharing Anna's experience have been truly phenomenal. As with all whānau we care for, we are left a little better for knowing them. The commitment that Anna had for breastfeeding Lou, for meeting his nutritional, emotional and spiritual needs, and enabling him, by creating that unique space, to transition from one parent's heart to another, moved me so very deeply. It was an unforgettable and transformative experience. I am motivated to offer this case study to colleagues and students in the hope that the insights I gained from my time with Anna and her family might help to inform others' journeys. Providing support for all who wish to breastfeed/chestfeed with the advocacy, advice and information to achieve their goals must be a midwifery priority.

Anna's reflection

When I started out on this journey, I never would have imagined the amazing impact and gift breastfeeding my adopted child would be.

At the beginning I wanted to do something to minimise loss. This newborn I was about to call my own was going to experience great loss, everything he knew about his world was going to change: the sounds, smells, tastes. So, by breastfeeding him, I hoped to help him through this transition and create a way for us to bond. I never intended to be the provider of all his food, but rather let breastfeeding him provide all the other things breastfeeding provides for baby and mother.

My supply built so much over time I was able to feed my son longer than I had initially hoped; I was able to feed him to natural term [baby-led weaning]. This in itself was a real gift.

What I didn't expect: I discovered raising my son was about a collection of mothers, all precious and needed in their own way. Firstly, his biological mother, then me his adopted [adoptive] mother, but also so many more. The many mothers who donated their breastmilk had such an impact on our lives. I thought of them as I fed my son with the lactaid. Connecting me and him to many. I am forever grateful for their generosity and love. Breastfeeding helped me create such a secure and beautiful bond with my son. I will treasure it always.

DISCUSSION

There are three key messages highlighted by this case study narrative.

Firstly, the intrapersonal and psychosocial factors that are part of the narrative were incorporated in a care plan providing holistic assessment and clinical decisions, acknowledging the gift of breastfeeding that carried a much larger significance than purely a nutritional choice. Secondly, the narrative demonstrates the importance of midwifery collegial support that encompasses the diversity of whānau, including LGBTQIA+ whānau, and the diversity of needs. And thirdly, re-telling, reflecting on and analysing the various elements in Anna's story offer an educational example for in-depth learning and understanding.

Care plans that incorporate holistic assessment alongside clinical decisions show the impact that midwifery care can have on an outcome. These outcomes include not only the physical but also the emotional and spiritual aspects of whānau wellbeing. The partnership we share speaks to the agency of a whānau, the becoming of a parent, and grows us as practitioners. Breastfeeding is not just about nutrition. Anna's deeply held belief about the absolute need for, and commitment to, breastfeeding to support Lou transitioning from one parent to another was inspirational. I am awestruck by her. Induced lactation can be achieved and done in a way that reflects the needs of each whānau.

Next, the collegial support among midwives is uplifting and supports the best outcomes for whānau and babies. Reaching out to each other and engaging collaboratively grow partnerships, knowledge and experience. Having the support of Alex's midwife who wanted the best outcome for all involved, enriched the experience. Together we held the respective spaces and now share a story. This was also evident in the support of the staff midwives immediately following birth, who enabled the hospital stay with sensitivity and caring.

Finally, the sharing of experiences and stories with each other enables shared learning. Education and learning continue beyond the classroom; we gain knowledge and insight from every whānau – including those we hear and read about, as well as those we attend. If we take this understanding forward, the service we offer is broadened and strengthened by it.

The scope of this article did not include the experiences of trans people; this is an area where further work is needed. However, this learning can be broadly applied and inform midwifery knowledge and care when supporting LGBTQIA+ whānau.

CONCLUSION

This case study has explored the physical and emotional complexities of induced lactation. Protocols to induce lactation have been discussed, with the woman's voice clearly heard throughout. The midwifery role, including the responsibility to provide a holistic assessment and care plan, which was an integral aspect of the successful outcome, has been described. The intention in presenting a detailed account of Anna's journey is to provide insights into aspects of the clinical case and, in doing so, illustrate broader lessons that may be learned (Crowe et al., 2011). I hope that the description of one woman's episode of care, alongside my own professional experiences, may inspire others to pursue and then share their own practitioner narratives of induced lactation as an important feature within the contemporary midwifery scope of practice. A final and vital point to make is that there is necessary work to be done to ensure equity for rainbow whānau who want to breastfeed/chestfeed their infants. We will see more opportunities to engage this developing knowledge and skill, as there are increasing rates of rainbow whānau growing their families and in surrogacy relationships.

GLOSSARY

Chestfeeding	Chestfeeding can refer to providing expressed donor milk at the chest of a non-lactating person, as well as being a gender-inclusive term for breastfeeding itself. In the context of this article, it is about the latter and not the former
Chest	For the purposes of this article, chest refers to breast tissue for people who identify as gender diverse and prefer not to use feminised terms
Cis-gendered	A person whose gender identity corresponds with the gender assigned to them at birth
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual. + acknowledges those whose identity is not covered by the letters used. Also known as "rainbow"
Pākehā	New Zealander of European descent
Parent	Indicates birth parent, biological parent, adoptive parent, who is female/assigned female at birth
Tauira	Student(s)
Whānau	Family group/extended family/to give birth

KEY POINTS

- Induced lactation is not common; this paper offers an opportunity for knowledge sharing and implementation into practice which is inclusive of rainbow communities.
- Induced lactation is a multilayered experience that often involves whānau and community for success.
- Induced lactation provides an opportunity to ease the transition of the newborn from birth parent to adoptive parent.

DECLARATION OF INTEREST

The author declares that she was also Anna's midwife.

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